MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

C6869 74
Reg. Dist. No.

8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County: Carroll

City or town: Rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yr., 4 mo., 22 days

Hospital, Institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 2 yr., 4 mo., 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: James Bare

3.(b) Social Security Number: 219-16-3398

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	divorced

6.(b) Name of husband or wife: Lavinia Harper

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 25, 1886

8. AGE: Years	Months	Days	If less than one day
60	--	24	hrs. min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual occupation: mechanic

11. Industry or business: automobile repair

FATHER 12. Name:

FATHER 13. Birthplace:

MOTHER 14. Maiden name: May Powers

MOTHER 15. Birthplace: Virginia

16. Informant: Springfield State Hospital Records

Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 7/23/46 (month) (day) (year)

Cemetery or crematory: Baltimore, National Cem.

Location: City

18. Funeral director: WIEDEFELD AND SON

Address: Greenmount Ave & 22nd Street

19. 7/22/46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 19, 1946, at 11:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 17, 1945 to July 19, 1946 and that I last saw him alive on July 19, 1946

Immediate cause of death	DURATION
Arteriosclerosis	2½ yrs.
Due to:	
Due to:	
Other conditions: Psychosis with cerebral arteriosclerosis	2½ yrs.

(Include pregnancy within 3 months of death)

Major findings of operation:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

Robert Bertrand May, M.D.

23. SIGNATURE: Robert Bertrand May M.D.
M. D. or other

Address: Springfield State Hospital, Sykesville, Maryland

Date signed: 7-20-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

C6870

Reg. Dist. No. 76

1. PLACE OF DEATH:

County Carroll Co.

City or town Rural near Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years

Hospital, Institution, or street address where death occurred: 90 Liberty St. Ext'd

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll Co.

City or town Rural near Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No. 90 Liberty St. Ext'd

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Ida Catherine Beard

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	widowed

6.(b) Name of husband or wife Edward H. Beard deceased 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 3, 1854

8. AGE: Years	Months	Days	If less than one day
91	7	23	..... hrs. ..... min.

9. Birthplace New Windsor, Carroll Co. Md. (Town, county, and state)

10. Usual occupation Home - wife

11. Industry or business

FATHER 12. Name Amos Caylor, Maryland

13. Birthplace ?

MOTHER 14. Maiden name Rachel E. Smith

15. Birthplace Carroll Co. Md.

16. Informant Miss Matie J. Beard

Address 90 Liberty St. Westminster Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 28 46 (month) (day) (year)

Cemetery or crematory Pipe Creek Cemetery

Location Near New Windsor Md.

18. Funeral director J. E. Myers - Jr.

Address Westminster Md.

19. 7/27 1946 (Date rec'd by registrar) H. Cleaver Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 1946, at 10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1940 to July 26 1946

and that I last saw h... alive on about June 15 1946

	DURATION
Immediate cause of death: Dilatation of Heart	about 6 yrs.
Due to: Chronic Myocarditis & Arteriosclerosis	6 yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE H. Cleaver M. D. or other

Address Westminster Date signed 7/27/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

66871

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr. 1 mo's, 16 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Pricce George's
City or town: Upper Marlboro
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: LILLY HILDA BELL

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept., 2, 1911

8. AGE: Years	Months	Days	If less than one day
34	10	1	..... hrs. ..... min.

9. Birthplace: Upper Marlboro (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business

FATHER
12. Name: Willie Bell
13. Birthplace: Upper Marlboro, Md.

MOTHER
14. Maiden name: Carrie Freeland
15. Birthplace: Upper Marlboro, Md.

16. Informant: Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 6 1946 (month) (day) (year)
Cemetery or crematory Union Cemetery
Location Upper Marlboro, Md.
18. Funeral director J. B. Johnson
Address Annapolis

19. 7/3 19 46 (Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 3, 1946, at 2.50A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 17, 1945, to July 3, 1946
and that I last saw her alive on July 3, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Dec. 1944
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: Reuben Hoffman M.D. M. D. or other
Address: Henryton, Md Date signed: 7/1/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

C6872

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 29 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1015 Creek Alley
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: EMILY RICHARDSON COX

3.(b) Social Security Number: 229-07-6641

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	married

6.(b) Name of husband or wife: Aaron Cox
6.(c) If alive, give age: 43 years

7. Birth date of deceased (mo., day, yr.): May 15, 1909

8. AGE: Years	Months	Days	If less than one day
37	1	24	hrs. min.

9. Birthplace: Cumberland, Va.
(Town, county, and state)

10. Usual occupation: Cleaner

11. Industry or business

FATHER
12. Name: Walter Richardson
13. Birthplace: Cumberland, Va.

MOTHER
14. Maiden name: Mary Scott.
15. Birthplace: Cumberland, Va.

16. Informant: Deceased
Address

17. Burial, cremation, or removal. Which? Burial Date thereof 7/13/46 (month) (day) (year)
Cemetery or crematory: Mt. Auburn Jul 13 46
Location: Balto Md

18. Funeral director: Mrs R R Williams
Address: 322 N. Broadway

19. 7/9 (Date rec'd by registrar) 19 46 Albert E Swanborn Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 9 1946, at 11.30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 10, 1946 to July 9, 1946 and that I last saw her alive on July 9, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Feb. 1946
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben H Fuman M.D.
M. D. or other
Address: Henryton, Md Date signed 7/9/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

C6873

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year, 19 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 129 N. Exeter St.,
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: HARRY DAVIS

3.(b) Social Security Number: 217-09-1840

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	Married

6.(b) Name of husband or wife: Louise Davis
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 25, 1892

8. AGE: Years	Months	Days	If less than one day
54	3	6	hrs. min.

9. Birthplace: Richmond, Va.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER
12. Name: Frank Davis
13. Birthplace: Unknown

MOTHER
14. Maiden name: Mary Davis
15. Birthplace: Georgia

16. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/5/46 (month) (day) (year)
Cemetery or crematory: Mt. Calvary Cem.
Location: A. A. County Md.

18. Funeral director: Joseph B. Lockard
Address: 1304 N. Central Ave.

19. 7/1 19 46 (Date rec'd by registrar)
Albert R. Brougham Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 1, 1946, at 6.00A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 12, 1945 to July 1, 1946 and that I last saw him alive on July 1, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	April 15, 1945
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben W. Fuson M. D.
M. D. or other
Address: Henryton, Md. Date signed: 7/1/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (BD)

CERTIFICATE OF DEATH

06874

Reg. Diat. No. 76

1. PLACE OF DEATH:

County CARROLL

City or town RURAL SMALLWOOD
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? LIFE

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County CARROLL

City or town RURAL SMALLWOOD
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME MARY ELIZABETH DAVIS

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	WIDOW

6.(b) Name of husband or wife ELIAS LEONARD DAVIS

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) DECEMBER 18, 1872

8. AGE:

Years	Months	Days	If less than one day
73	6	23	..... hrs. ..... min.

9. Birthplace CARROLL COUNTY, MD.
(Town, county, and state)

10. Usual occupation NONE

11. Industry or business

FATHER
12. Name LEWIS DITMAN
13. Birthplace MARYLAND

MOTHER
14. Maiden name MARTHA ROSENBERGER
15. Birthplace MARYLAND

16. Informant MRS. THOMAS ROWE
Address SMALLWOOD, MD.

17. BURIAL Date thereof 7/14/46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory DEER PARK CEM.

Location SMALLWOOD, MD.

18. Funeral director J. FRANCIS REESE

Address WESTMINSTER, MD.

19. 7/12 19 46 [signature] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 11th 1946 at 2:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19.. to July 11- 1946.

and that I last saw h[illegible] alive on July 11th 1946

Immediate cause of death acute cardiac dilatation — DURATION 15 Minutes

Due to Chronic Myocarditis — DURATION Several years

Due to .....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Chas R. Foutz M.D.
M. D. or other

Address Westminster Md. Date signed 7-11-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (462)

CERTIFICATE OF DEATH

(★) 06875 Reg. Dist. No. 70

1. PLACE OF DEATH:

County Carroll

City or town Rural - Taneytown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Rural - Taneytown

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Norman John Edward Diehl

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 25, 1891

8. AGE:

Years	Months	Days	If less than one day
54	9	27	hrs. min.

9. Birthplace Taneytown - Carroll Co. - Md.
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER

12. Name George H. Diehl

13. Birthplace Maryland

MOTHER

14. Maiden name Susie Stevig

15. Birthplace Maryland

16. Informant Ray Diehl

Address Taneytown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 24, 1946 (month) (day) (year)

Cemetery or crematory St. Mathews Cemetery

Location Pleasant Valley, Md.

18. Funeral director C. O. Fuss & Son

Address Taneytown, Md.

19. July 24 1946 Ethel M. Mehring
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 22 1946 at 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 7 1946, to July 22 1946

and that I last saw him alive on July 18 1946

	DURATION
Immediate cause of death: Malnutrition	1 Month
Due to: Carcinoma of the Colon	2 Yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Carcinoma of the Colon

Date of op. Dec. 1944

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. S. McVaugh M.D.
M. D. or other

Address Taneytown, Md. Date signed 7/23/46

(M)

(I)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be sure correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45.15M


RECEIVED
JUL 25 1946
BUREAU V S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 06876 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yr 11 mo 1 da

Hospital, institution, or street address where death occurred: Spring Field State Hospital

How long in hospital or institution? 3 yr 11 mo 1 da

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 509 E 21st St.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Louise Dressel

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	divorced

6.(b) Name of husband or wife: Ernst L Krause

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March -3- 1866

8. AGE:

Years	Months	Days	If less than one day
80	4	27	hrs. min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual occupation: housework

11. Industry or business: at home

FATHER

12. Name: Friedrich Schaffer

13. Birthplace: Germany

MOTHER

14. Maiden name: Kunigunde Dressel

15. Birthplace: Germany

16. Informant: Miss Margarita Bowers

Address: 509 E 21st St Balto

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 1- 46 (Month) (day) (year)

Cemetery or crematory: Balto. Mem.

Location: E North Ave

18. Funeral director: John. E. Hagan

Address: 3000 E. Balto. Md.

19. July 31 1946 (Date rec'd by registrar) C. Harry Weese Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 30th 1946, at 7.55 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 28 1942 to July 30 1946 and that I last saw her alive on July 30 1946

Immediate cause of death	DURATION
Lobar Pneumonia	2 da
Due to: Thrombosed Mesentaric vessels	2 da
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Lobar Pneumonia Date of op.

Autopsy results: Mesenteric thrombosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: W. P. Maston M.D. M. D. or other

Address: Sykesville md Date signed: 7/30/46

VS A15 9.45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

06877 Reg. Diat. No. 24

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 mo 17 da

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 2 mo 17 da

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County: Garrett Co

City or town: Oakland (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Lydia Fichtner

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

8.(b) Name of husband or wife: Clarence Ray Fichtner 6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): March 5th 1874.

8. AGE: Years 72 | Months 4 | Days 25 | If less than one day ____ hrs. ____ min.

9. Birthplace: West Virginia (Town, county, and state)

10. Usual occupation: housework

11. Industry or business:

FATHER — 12. Name: Peter Tike

FATHER — 13. Birthplace: W Va

MOTHER — 14. Maiden name: Christian King

MOTHER — 15. Birthplace: W Va

16. Informant: Clarence Ray Fichtner

Address: Oakland Md Rd #2

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-2-46 (month) (day) (year)

Cemetery or crematory: Davis

Location: Davis, W. Va.

18. Funeral director: C. Harry Wee

Address: Sykesville, Md.

19. July 31 1946 (Date rec'd by registrar) C. Harry Wee Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 31 1946, at 1 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 13 1946, to July 31 1946

and that I last saw h[illegible] alive on July 31 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	4 da
Due to: Sent Arterio Sclerosis	3
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE: W H Wastin M. D., or other

Address: Sykesville Md Date signed 7-31-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73)

CERTIFICATE OF DEATH

7476

Reg. Dist. No. 24831

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Woods Mill

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 32 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Carroll

City or town: Woods Mill

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Lyksville P.O.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Carrie A. Fisher

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W	Married

6.(b) Name of husband or wife: Benjamin L. Fisher

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 28, 1882

8. AGE:

Years	Months	Days	If less than one day
64	4	2	hrs. min.

9. Birthplace: Md. (Town, county, and state)

10. Usual occupation: House Wife

11. Industry or business: Home

FATHER

12. Name: Wm. F. Trowbridge

13. Birthplace: Pa.

MOTHER

14. Maiden name: Annie A. Shoemaker

15. Birthplace: Md.

16. Informant: Mr. Benjamin L. Fisher

Address: Woodbine, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 6 1946 (month) (day) (year)

Cemetery or crematory: Springfield Cemetery

Location: Lyksville, Md.

18. Funeral director: C. Harry Wenz

Address: Lyksville, Md.

19. July 5 1946 (Date rec'd by registrar) C. Harry Wenz Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 2 1946 at 11 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1939, to July 2 1946, and that I last saw her alive on July 1 1946

Immediate cause of death: Cardio Vascular Disease

	DURATION
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. R. Bamer MD M. D. or other

Address: Sykesville Md. Date signed: 7/3/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 06878 76

1. PLACE OF DEATH:

County: Carroll

City or town: Westminster - Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?:

Hospital, institution, or street address where death occurred:

Baltimore blvd

How long in hospital or institution?:

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Westminster - Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Balto. blvd.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Harry Martin Fowler

3. (b) Social Security Number: 218-01-4582

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of ~~husband or~~ wife: Ida F. Fowler

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): June 1 - 1879

8. AGE: Years: 67 | Months: 1 | Days: 18 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Carroll County, Md

(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: by day

FATHER — 12. Name: George Fowler

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Charlotte Fowler

MOTHER — 15. Birthplace: Maryland

16. Informant: Ira M. Fowler

Address: Westminster, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 22 - 1946 (month) (day) (year)

Cemetery or crematory: Methodist Cemetery

Location: Uniontown, Md.

18. Funeral director: H. H. Hartsler & Sons

Address: Union Bridge & New Windsor, Md

19. 7/20 1946 (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 19 1946 at 5 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 14 1946, to July 19 1946 and that I last saw him alive on July 19 1946

	DURATION
Immediate cause of death: Coronary Thrombosis	5 da
Due to: Coronary Sclerosis	1 yr.
Due to: Myocardial degeneration	
Due to: Senile Debility	
Other conditions: Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. Glenn Speicher M. D. or other

Address: Westminster, Md Date signed: 7/20/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

C6879 P

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County: Carroll

City or town: Taylorsville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yr 5 mo 3 da

Hospital, institution, or street address where death occurred: Spring Field State Hosp.

How long in hospital or institution? 2 yr 5 mo 5 da

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County:

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No.: (If rural, give LOCATION)

2.(a) If veteran, name war: V

3.(a) FULL NAME: Honorah Gannon

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W	Widowed

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1871

8. AGE: Years: 75 Months: Days: If less than one day: hrs. min.

8. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business:

FATHER 12. Name: Michael Conviglia

13. Birthplace: Maryland

MOTHER 14. Maiden name: Alice Jane Patrick

15. Birthplace: Maryland

16. Informant: David Cramer

Address: 1102 Glenmount Ave Balto

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 22, 1946 (month) (day) (year)

Cemetery or crematory: Cathedral

Location: Baltimore

18. Funeral director: Rita Wrubel

Address: 900 East Biddle St.

19. 7/22 1946 A.W. Hedrick DM Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 20 1946, at 7-50 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 15 1944 to July 20 1946 and that I last saw h-er alive on July 20 1946

Immediate cause of death: Chronic Myocarditis — DURATION 5 yrs

Due to: Arteriosclerosis — 5 yrs

Due to: Hypertension — 5 yrs

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: J. F. Gastrock M. D. Other

Address: Taylorsville Md. Date signed 7/22/46

MARYLAND STATE DEPARTMENT OF HEALTH

C6880

2411 N. Charles St., Baltimore (74a)

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:

County: Carroll

City or town: Rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 yr., 7 mo., 3 days

Hospital, Institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 14 yr., 7 mo., 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Daniel Carter Gittings

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 21, 1891

8. AGE: Years	Months	Days	If less than one day
55	3	13	hrs. min.

9. Birthplace: Baltimore City, Maryland
(Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER 12. Name: James C. Gittings

FATHER 13. Birthplace: Maryland

MOTHER 14. Maiden name: Emma Gist

MOTHER 15. Birthplace: West Virginia

16. Informant: Springfield State Hospital Records

Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 6, 1946 (month) (day) (year)

Cemetery or crematory: Springfield Cemetery

Location: Sykesville, Md.

18. Funeral director: C. Harry Klee

Address: Sykesville, Md.

19. July 5 1946 (Date rec'd by registrar) C. Harry Klee Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 4 1946 at 8:05a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1943 to July 4 1946 and that I last saw him alive on July 3 1946

Immediate cause of death	DURATION
Coronary artery disease	8 days
Due to	
Due to	
Other conditions: Paranoid condition	life

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

Robert Bertrand May, M.D.

23. SIGNATURE: Robt Bertrand May, M.D.
M. D. or other

Springfield State Hospital
Sykesville, Maryland
Address

Date signed 7-4-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45-15

RECEIVED
JUL 6 1946
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (162-A)

CERTIFICATE OF DEATH

06681

Reg. Diat. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year, 20 days

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 1 year, 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: rural near Williamsport
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: George Clinton Gossard

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	single

6.(b) Name of husband or wife

B.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): September 18, 1880

8. AGE: Years	Months	Days	If less than one day
65	10	00	..... hrs. ..... min.

9. Birthplace: Bushler, Illinois
(Town, county, and state)

10. Usual occupation: laborer

11. Industry or business: agriculture

FATHER 12. Name: Jerome Gossard

FATHER 13. Birthplace: [redacted]

MOTHER 14. Maiden name: Savannah Farmer

MOTHER 15. Birthplace: Maryland

18. Informant: Springfield State Hospital Records

Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 20 46 (month) (day) (year)

Cemetery or crematory: Cemetery

Location: Williamsport

18. Funeral director: Edith V. Seat

Address: Williamsport md

19. July 18 1946 (Date rec'd by registrar) C. Harry Weu Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 18 1946, at 3:30a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1 1945, to July 18 1946

and that I last saw him alive on July 17 1946

Immediate cause of death	DURATION
Senility	2 yrs.
Due to	
Due to	
Other conditions: Senile psychosis, simple deterioration	2 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Robert Bertrand May, M.D.

23. SIGNATURE: Robert Bertrand May, M.D.
M. D., or other

Springfield State Hospital
Sykesville, Maryland

Address Date signed 7-18-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr 10 mos 9 da
Hospital, institution, or street address where death occurred: Springfield State Hospital
How long in hospital or institution? 1 yr 10 mos 11 da

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1 N Highland Ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Clara Gunther

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Dec. 25, 1880

8. AGE: Years: 65 Months: 7 Days: 6 If less than one day: hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: dependent

11. Industry or business:

FATHER — 12. Name: Fredrick Gunther
13. Birthplace: Maryland

MOTHER — 14. Maiden name: Elizabeth Evans
15. Birthplace: Maryland

16. Informant: Mrs Leonard Williams
Address: 1 N Highland Ave Balto

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 8-3-46 (month) (day) (year)
Cemetery or crematory: Mount Carmel
Location: Baltimore, Md.

18. Funeral director: Henry Sander & Sons, Inc.
Address: North Ave. & Broadway

19. 8/2 46 (Date rec'd by registrar) H. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 31 1946 at 10:50 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept 2nd 1944 to July 31 1946 and that I last saw h— alive on July 31 1946

Immediate cause of death	DURATION
Coronary Occlusion	1 hr
Due to: Senile Arterio Sclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: W. J. Maston M.D. M. D. or other
Address: Sykesville Md. Date signed: 7/31/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

C6883

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:
County Carroll Co.
City or town Rural near Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? About 3 years
Hospital, Institution, or street address where death occurred:
Charles St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Carroll
City or town Rural near Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No. Charles St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Earnest H. Holt

3.(b) Social Security Number ?

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widowed

8.(b) Name of husband or wife Helen J. Holt deceased
8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) About 1900

8. AGE:

Years	Months	Days	If less than one day
46			..... hrs. ..... min.

9. Birthplace Baltimore Md. ?
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden name Amaza Holt Warner
15. Birthplace Virginia

16. Informant Mrs. Harry Burgess (BURGESS)
Address Charles St. Westminster Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 21, 46 (month) (day) (year)
Cemetery or crematory Ellsworth Cemetery
Location Near Westminster Md.

18. Funeral director J. E. Myers Jr.
Address Westminster

19. (Date rec'd by registrar) 1946 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 18th 1946 at 7 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 16 1946 to July 18 1946 and that I last saw h. alive on July 18 1946

	DURATION
Immediate cause of death	
Acute Pulmonary Hemorrhage	1 hr.
Due to Phthisis Pulmonalis.	2 yr.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Hunter Bon (Med.) M. D. or other
Address Westminster, Md. Date signed 7/18/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

06884

Reg. Dist. No. 7-1

1. PLACE OF DEATH:
County: Carroll
City or town: Linwood
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 months.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Carroll
City or town: Linwood
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Joseph B. Horton

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of ~~husband~~ or wife: Jennie Horton
deceased 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 8, 1864

8. AGE: Years	Months	Days	If less than one day
81	6	29	..... hrs. ..... min.

9. Birthplace: Carroll Co. Md.
(Town, county, and state)

10. Usual occupation: Farmer retired

11. Industry or business

FATHER
12. Name: Ira Horton
13. Birthplace: Maryland

MOTHER
14. Maiden name: Harriett Frizzell
15. Birthplace: Maryland.

16. Informant: Walter J. Horton
Address: Linwood. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-10-46 (month) (day) (year)
Cemetery or crematory: Sams Creek Brethren
Location: Deming's, Carroll Co., Md

18. Funeral director: C. M. Wolfe
Address: Winfield. Md.

19. July 15 1946 (Date rec'd by registrar) Margaret P. Engle Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 8 1946 at 12:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 8 1942, to July 7 1946
and that I last saw h.... alive on July 7 1946.

	DURATION
Immediate cause of death: Cerebral Hemorrhage	Several years
Due to: Senility	
Due to:	
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: C. F. Billingslea, M.D.
M. D. or other
Address: Westminster, Md. Date signed 7-9-46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING


RECEIVED
JUL 19 1946
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

P6885

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs 7 mos - 9 da

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 2 yrs 7 mos 9 da

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3308 Windsor Ave

(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3. (a) FULL NAME Elva Gaskins Hurst

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov 17th - 1870

8. AGE: Years 75 | Months 8 | Days 1 | If less than one day ..... hrs. ..... min.

9. Birthplace Virginia (Town, county, and state)

10. Usual occupation Office Work

11. Industry or business

FATHER 12. Name Sandy Hurst

13. Birthplace Virginia

MOTHER 14. Maiden name Maria Gaskins

15. Birthplace Virginia

16. Informant Sandy Hurst Brother

Address R 2, Summit Grove Indep. Pa

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/20/46 (month) (day) (year)

Cemetery or crematory White Marsh

Location Kilmarnock, Va.

16. Funeral director John O. Mitchell & Sons, Inc.

Address 1900 Eutaw Place, Balto. Md.

19. July 18 1946 (Date rec'd by registrar) C. Henry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 18 1946, at 4-45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 8 1944, to July 18 1946 and that I last saw her alive on July 18th 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	48 hrs
Due to	
Due to Arteriosclerosis	?
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE W. J. Gaston M.D. M. D. or other

Address Sykesville Md. Date signed 7/18/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(13L)

06886

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 23 days
Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 613 N. Eden Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: JOHN HENRY JENKINS

3.(b) Social Security Number: 243-16-6287

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	married

6.(b) Name of husband or wife: Jennie Jenkins
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 25, 1873

8. AGE: Years	Months	Days	If less than one day
73	4	5	hrs. min.

9. Birthplace: Greenville, N. C. (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business

FATHER
12. Name: William Jenkins
13. Birthplace: Greenville, N. C.

MOTHER
14. Maiden name: Unknown
15. Birthplace: North Carolina

16. Informant: Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 4, 1946 (month) (day) (year)
Cemetery or crematory: Mt Calvary
Location: Brooklyn Md
18. Funeral director: Elroy S. Wilson
Address: 1000 Brantley ave

19. 7/30 (Date rec'd by registrar) 19 46 Albert R. Counihan Deputy Local Registrar

MEDICAL CERTIFICATION 46

20. DATE OF DEATH: July 30, 1945 at 10.30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 25, 1946 to July 30, 1946 and that I last saw him alive on July 30, 1946

Immediate cause of death	Pulmonary Tuberculosis	DURATION: Unknown
Due to		
Due to		
Other conditions		

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hofman, M.D. M. D. or other
Address: Henryton, Md. Date signed: 7/30/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06887

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 Yr. 6 Mo's, 23 days
Hospital, Institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 123 N. Pine Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: WILLIE WARREN LANGLEY

3.(b) Social Security Number: 220-09-2444

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 29, 1913

8. AGE: Years	Months	Days	If less than one day
33	1	9	hrs. min.

9. Birthplace: Greenville, N. C.
(Town, county, and state)

10. Usual occupation: Kitchen Helper

11. Industry or business:

FATHER
12. Name: William Langley
13. Birthplace: Greenville, N. C.

MOTHER
14. Maiden name: Harriet Hardy
15. Birthplace: Greenville, N. C.

16. Informant: Deceased
Address:

17. Shipped (Burial, cremation, or removal. Which?) Date thereof 7/8/46 (month) (day) (year)

Cemetery or crematory:
Location: Greenville S C

18. Funeral director: Chas H. Alexander
Address: 1200 W C Colloh St

19. 7/8 (Date rec'd by registrar) 19 46 Albert R. Brumbaugh Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 8 19 46 at 8.00P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 15 19 45 to July 8, 19 46 and that I last saw him alive on July 8, 19 46

Immediate cause of death: Pulmonary Tuberculosis — DURATION: Sept. 1944

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operation:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben T. Freeman M.D.
M. D. or other
Address: Henryton, Md Date signed: 7/8/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

C6888

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (168)

CERTIFICATE OF DEATH

Reg. Dist. No. 24

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 44yrs 6 mo. 28 da.
Hospital, Institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 44yrs 6 mo 28 da.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)
Street No. 1626 Bond Street (If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Victoria Makoska

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: Peter Makoska
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): unknown

8. AGE: Years	Months	Days	If less than one day
apparent age 65			hrs. min.

9. Birthplace: Poland (Town, county, and state)
10. Usual occupation: none
11. Industry or business: none

FATHER
12. Name: unknown
13. Birthplace: unknown

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: Hospital records
Address: Springfield State Hospital

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 9 1946 (month) (day) (year)
Cemetery or crematory: Springfield Hosp. Cem.
Location: Sykesville, Md.
18. Funeral director: C. Harry Weer
Address: Sykesville, Md.
19. July 9 1946 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 3 1946, at 8:40 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Strangulation -	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations: None
Date of op.
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: homicide Date of July 3-46
Where did injury occur? Sykesville (City or town) Carroll (County) Md (State)
Injured at home, farm, industry, public place (where?) Springfield State Hosp.
Means of injury: Cotton Cloth. Injured at work? No

23. SIGNATURE: James T. Wood Deputy Medical Examiner M. D. or other
Address: Westminster Md Date signed 7/3/46


RECEIVED
JUL 11 1946
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★ 06889

Reg. Dist. No. 24

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 yrs 8 mo 2 da.

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 7 yrs 8 mo 2 da

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 1602 East Fort Avenue (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Bridget Malone

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): unknown 1873

8. AGE: Years: 73 ? Months: Days: If less than one day: hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: none

11. Industry or business: none

FATHER — 12. Name: Thomas Malone

FATHER — 13. Birthplace: Ireland

MOTHER — 14. Maiden name: Mary Cassy

MOTHER — 15. Birthplace: Ireland

16. Informant: Hospital Records

Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 23, 1946 (month) (day) (year)

Cemetery or crematory: Holy Cross Cemetery

Location: Balto. Md.

18. Funeral director: Charles F. Dill

Address: 1501 E. Fort Ave. Balto. Md.

19. July 22 1946 (Date rec'd by registrar) C. A. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 20 1946 at 4.30 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 18, 1938 to July 20 1946 and that I last saw h... or ...alive on July 20, 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	4 da.
Due to	
Due to	
Other conditions: Schizophrenia--paranoid Type	20 yrs

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Maud M. Lee M.D. M. D. or other

Address: Sykesville, Md. Date signed 7-24-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06890

Reg. Diat. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 mo., 20 days

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 1 mo., 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Baltimore City

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 21 N. Stricker St.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Walter Lee McGill

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Margaret Halstead

6.(c) If alive, give age: 26 years

7. Birth date of deceased (mo., day, yr.): Nov. 23, 1900

8. AGE: Years	Months	Days	If less than one day
45	7	20	....hrs. ....min.

8. Birthplace: Atlanta, Ga.
(Town, county, and state)

10. Usual occupation: Radio repair work

11. Industry or business

FATHER
12. Name: Walter A. McGill
13. Birthplace: Scotland

MOTHER
14. Maiden name: Ida Viola Goldsmith
15. Birthplace: Maryland

16. Informant: Wife
Address: 21 N. Stricker St., Baltimore, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 16-1946 (month) (day) (year)

Cemetery or crematory: Good Shepard

Location: Rockland Md

18. Funeral director: Geo. L. Beyer Jr

Address: 1512 Hollins St

19. 7-15 19 46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 13, 1946, at 10:15 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 23, 1946, to July 13, 1946

and that I last saw h.im alive on July 13, 1946

Immediate cause of death: Psychosis with syphilitic meningo-encephalitis — DURATION: 4 months since 5/23/46

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Joseph H. Marshall, M.D. M.D. or other

Address: Springfield State Hospital Date signed: 7/14/46

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06891

Reg. Diat. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 days

Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 532 S. Paca Street
(If roral, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: DAVID McNEIL

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	married

6.(b) Name of husband or wife: Maggie McNeil

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 17, 1913

8. AGE:

Years	Months	Days	If less than one day
32	8	20	hrs. min.

9. Birthplace: Raeford, N.C.
(Town, county, and state)

10. Usual occupation: Truck Driver

11. Industry or business:

FATHER
12. Name: James Willis
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-10-46 (month) (day) (year)

Cemetery or crematory: Mt Calvary Cem

Location: a a, Co Md

18. Funeral director: Isaiah L Brown & Son

Address: 108 W Montgomery St

19. July 7, 1946 (Date rec'd by registrar) Albert R. Swanborough Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 7, 1946, at 1:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 27, 1946, to July 7, 1946 and that I last saw him alive on July 7, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Dec. 20, 1945
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other

Address: Henryton, Md. Date signed: 7-7-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06892

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr. 10 mo's, 14 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County St. Mary's
City or town Chaptico
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Pearl Madeleine Miles

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 16, 1913

8. AGE: Years	Months	Days	If less than one day
33	5	13	hrs. min.

9. Birthplace Chaptico, Md.
(Town, county, and state)
10. Usual occupation Domestic
11. Industry or business
FATHER 12. Name John H. Miles, Sr.
13. Birthplace St. Mary's Co., Md.
MOTHER 14. Maiden name Ella Counters
15. Birthplace Chaptico, Md.
16. Informant Deceased
Address
17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/1/46 (month) (day) (year)
Cemetery or crematory St. Joseph's
Location Morganza, Md.
18. Funeral director Josey E. Welch
Address Chaptico, Md.
19. 7/29/46 (Date rec'd by registrar) Albert A. Swann Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 29, 1946 at 8.00P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 15, 1944 to July 29 1946
and that I last saw h[illegible] alive on July 29, 1946

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	Aug. 6th 1944
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Nelson W Brown, M.D.
M. D. or other
Address Henryton, Md. Date signed 7/29/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

7475

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (17)

CERTIFICATE OF DEATH

Reg. Diat. No. 81

1. PLACE OF DEATH: Carroll

County ~~Frederick~~

City or town Union Bridge

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Union Bridge

(If outside city or town limits, write RURAL and give nearest town)

Street No. Same

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Fannie Stately Myers

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife William B Myers

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) December 8 - 1868

8. AGE:

Years	Months	Days	If less than one day
77	6	29	..... hrs. ..... min.

9. Birthplace Frederick Co Maryland

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business At Home

FATHER

12. Name John Stately

13. Birthplace Maryland

MOTHER

14. Maiden name Susanna Buffington

15. Birthplace Maryland

16. Informant Mr Truman Myers

Address Union Bridge Md R. 2

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 10-1946 (month) (day) (year)

Cemetery or crematory Pipe Creek Cemetery

Location Uniontown Road

18. Funeral director D. D. Hartzler & Son

Address Union Bridge & New Windsor Md.

19. July 9 1946 (Date rec'd by registrar) M. Eichman Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7 1946 at 4.00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 26 1946 to July 7 1946 and that I last saw h... alive on July 7 1946

Immediate cause of death	DURATION
Arteriosclerosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE J. H. Legg MD M. D. or other

Address Uniontown Md Date signed 7-8-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

7477

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

Reg. Dist. No. 83

1. PLACE OF DEATH:

County Carroll

City or town Rural - Winfield

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Pleasant Valley

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME William Henry Myers

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Sarah Josephine Roser

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 21 1864

8. AGE: Years	Months	Days	If less than one day
82	4	18	..... hrs. ..... min.

9. Birthplace Pleasant Valley - Carroll - Md.
(Town, county, and state)

10. Usual occupation Retired Farmer

11. Industry or business

FATHER 12. Name William Myers

13. Birthplace Pleasant Valley Md.

MOTHER 14. Maiden name Lydia Wantz

15. Birthplace Md.

16. Informant Mrs. Ed. Hewitt

Address Winfield, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 11, 1946 (month) (day) (year)

Cemetery or crematory Pleasant Valley Cemetery

Location Pleasant Valley Md.

18. Funeral director C. O. Dudderar & Son

Address Taneytown, Md.

19. July 11 1946 (Date rec'd by registrar) Edna M. Hewitt Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9 1946, at 1:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1946, to July 9 1946

and that I last saw h~~im~~ alive on July 8 1946

Immediate cause of death	DURATION
(a) Coronary Thrombosis	4 hrs
Due to (b) Myocardial degeneration	
Due to (c) Arteriosclerosis General	
Due to	
Other conditions Hypertrophy of Prostate.	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. Glenn Speicher M. D. or other

Address Westminster, Md. Date signed 7/9/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

06893

Reg. Diat. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 11 days

Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Prince George's

City or town: Upper Marlboro
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: MARY ODEN

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 27, 1925

8. AGE: Years	Months	Days	If less than one day
21	3	27	..... hrs. ..... min.

9. Birthplace: Upper Marlboro, Md.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER — 12. Name: Charles Ford

FATHER — 13. Birthplace: Upper Marlboro, Md.

MOTHER — 14. Maiden name: Irene Oden

MOTHER — 15. Birthplace: Upper Marlboro, Md.

16. Informant: Donelson Christmas

Address: Upper Marlboro, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-26-46 (month) (day) (year)

Cemetery or crematory: Mt Carmel

Location: Upper Marlboro Md

18. Funeral director: L B Johnson

Address: Annapolis, Md

19. 7/24 (Date rec'd by registrar) 19 46 Albert [illegible] Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 24, 1946 at 4.40A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 13, 1946 to July 24, 1946

and that I last saw h... alive on ... 19...

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	Feb. 15, 1946
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. (M. D. or other)

Address: Henryton, Md. Date signed 7/24/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

06894

Reg. Diat. No. 70

1. PLACE OF DEATH:

County: Carroll

City or town: Rural - Taneytown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 60 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Rural - Taneytown

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: John William Reck

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Mary L. Reck

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 14, 1857

8. AGE:

Years	Months	Days	If less than one day
88	9	10	hrs. min.

9. Birthplace: Adams Co - Penna.

(Town, county, and state)

10. Usual occupation: Cigar maker

11. Industry or business

FATHER — 12. Name: Samuel D. Reck

FATHER — 13. Birthplace: Pa.

MOTHER — 14. Maiden name: Catherine Allison

MOTHER — 15. Birthplace: Pa.

16. Informant: Mrs Charles Reck

Address: Manchester, Md.

17. Burial (Burial, cremation, or removal, Which?) Date thereof July 26, 1946 (month) (day) (year)

Cemetery or crematory: United Brethren Cemetery

Location: Harney - Md.

18. Funeral director: C. O. Guss & Son

Address: Taneytown, Md.

19. July 26 1946 Ethel M Mehring

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: JULY 24 1946 at 6:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from JUNE 15 1946, to JULY 24 1946 and that I last saw h. l. M. alive on JULY 23 1946

Immediate cause of death	DURATION
CHRONIC MYOCARDITIS & MYOCARDIAL	
DEGENERATION	1 MONTH
Due to ARTERIOSCLERDSIS	10 YEARS
Due to	
Other conditions SENILITY	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: L. L. Potter M.D.

M. D. or other

Address: Littlestown, Pa Date signed: July 24 1946

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (17)

CERTIFICATE OF DEATH

★ 06895

Reg. Dist. No. 7H

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yr., 9 mo., 17 days

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 4 yr., 9 mo., 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Carl M. Russell

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Elsie

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 10, 1882

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
63	10	10		

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Printer

11. Industry or business:

FATHER
12. Name: James A. Russell
13. Birthplace: Kent County, Maryland

MOTHER
14. Maiden name: Amanda Sparks
15. Birthplace: Kent County, Maryland

16. Informant: Springfield State Hospital Records
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 23, 1946 (month) (day) (year)

Cemetery or crematory: CHESTER. CEM.

Location: CHESTERTOWN, Md.

18. Funeral director: J. Willis Wells

Address: CHESTERTOWN, Md.

19. July 21 1946 (Date received by registrar) C. Henry Ellers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 20 1946 at 2:20p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1943 to July 20 1946 and that I last saw him alive on July 20 1946

Immediate cause of death	DURATION
Arteriosclerosis	5 yrs.
Due to	
Due to	
Other conditions: Psychosis with chronic alcoholism, plus ateriosclerosis	5 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

Robert Bertrand May, M.D.

23. SIGNATURE: Robert Bertrand May, M.D.
Springfield State Hospital M. D. or other
Sykesville, Maryland
Address: Date signed 7-20-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

06896 Reg. Diat. No. 70

1. PLACE OF DEATH:

County Carroll

City or town Taneytown R.D.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Carroll

City or town Rural-Taneytown
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mrs. Effie B.Sauble

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6.(b) Name of husband or wife John H.Sauble 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb.8,1876

8. AGE: Years	Months	Days	If less than one day
70	5	20	hrs. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual occupation housewife

11. Industry or business

FATHER 12. Name James T.Shorb

13. Birthplace Md

MOTHER 14. Maiden name Sarah Six

15. Birthplace Md.

16. Informant John H. Sauble

Address Taneytown,Md.R.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 31,1946. (month) (day) (year)

Cemetery or crematory Keysville

Location Keysville,Md.

18. Funeral director C.O.FUSS & SON

Address Taneytown,Md.

19. July 31. 1946 Ethel M Mehring
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28 1946 at 9 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 21 1939, to July 25 1946 and that I last saw h.e.r. alive on July 25 1946

	DURATION
Immediate cause of death Coronary Occlusion	Few Min.
Due to Arteriosclerosis and Chronic Myocarditis	10 Yrs.
Due to	
Other conditions Chronic Cholecystitis	10 yrs.
Chronic Arthritis	10 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. S. McVaugh M.D.
M. D. or other

Address Taneytown, Md. Date signed 7/30/46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully; the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-C)

06897

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 months
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1721 Cairo Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: BETTY SCOTT

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	Widow

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 7, 1867

8. AGE: Years	Months	Days	If less than one day
79	0	16	hrs. min.

9. Birthplace: Cumberland Co., Va.
(Town, county, and state)
10. Usual occupation: None
11. Industry or business:

FATHER
12. Name: Moses Venable
13. Birthplace: Virginia

MOTHER
14. Maiden name: Louise Johnson
15. Birthplace: Unknown

16. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-24-46 (month) (day) (year)
Cemetery or crematory: Mt. Auburn
Location: Baltimore City.
18. Funeral director: Geo. G. Kelsum
Address: 1303 Presstman. St.

19. 7/23 19 46 (Date rec'd by registrar) Albert R. Swanbum Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 23, 19 46, at 4.20A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 23, 19 46, to July 23, 19 46
and that I last saw her alive on July 23, 19 46

Immediate cause of death	DURATION
Hypertensive Cardiovascular Renal Disease	Sept. 1945
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben W. Freeman, M.D.
M. D. or other
Address: Henryton, Md. Date signed: 7/23/46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94-a)

06898

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 5606 Purdue Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3.(a) FULL NAME Francis Shipley

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W	Widowed

8.(b) Name of husband or wife Esther M. Shipley

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 15, 1875

8. AGE: Years	Months	Days	If less than one day
71	3	3	..... hrs. ..... min.

9. Birthplace Md.

(Town, county, and state)

10. Usual occupation Railroad Maintenance Man

11. Industry or business B. & O. R. R.

FATHER 12. Name Henry Shipley

13. Birthplace Md.

MOTHER 14. Maiden name Susan Bidinger

15. Birthplace Md.

16. Informant Mrs. Esther Foote

Address 5606 Purdue Ave. Balto. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 20, 1946 (month) (day) (year)

Cemetery or crematory Druids Ridge Cem.

Location Pikesville, Md.

18. Funeral director C. Harry Ewen

Address Sykesville, Md.

19. July 18 1946 C. Harry Ewen

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 18 1946 at 7:30 A M Prior to

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary Occlusion.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide None Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James T. Marsh Deputy Medical Examiner

M. D. or other

Address Westminster Md. Date signed 7/18/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (742)

CERTIFICATE OF DEATH

06899

Reg. Dist. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll
City or town Rural Westminster # 6 (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Carroll
City or town Rural Westminster # 6 (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Noah E. Sies

3.(b) Social Security Number 218-05-1518

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife Mabel R. Teed
B.(c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) Dec. 31 - 1877

8. AGE:	Years	Months	Days	If less than one day
	68	6	22	...hrs. ...min.

9. Birthplace Carroll Co. Md. (Town, county, and state)
10. Usual occupation Brick layer
11. Industry or business
FATHER 12. Name Noah Sies
13. Birthplace Md.
MOTHER 14. Maiden name Not known
15. Birthplace " "
16. Informant Mabel R. Sies
Address Westminster R.D. # 6
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 26-1946 (month) (day) (year)
Cemetery or crematory Westminster Cemetery
Location Westminster, Md.
18. Funeral director H. Bankard & Son
Address Westminster Md.
19. 7/25 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 24th 1946 at 6 30 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 10 1945, to July 24th 1946 and that I last saw h... alive on July 23rd 1946

Immediate cause of death	DURATION
Acute Coronary Thrombosis	30 minutes
Due to Generalized Arteriosclerosis -	10 years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Walter Bon (M.D.) M. D. or other
Address Westminster Md. Date signed 7/25/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

06900 C

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs, 1 mo, 4 days.

Hospital, institution, or street address where death occurred:

Springfield State Hospital.

How long in hospital or institution? 2 yrs, 1 mo, 4 days.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: -----

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 2680 St. Benedict St. (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: LILLIAN SLARK

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): June 6, 1922

8. AGE: Years	Months	Days	If less than one day
24	1	12	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: none

11. Industry or business:

FATHER — 12. Name: Frank, Slark,

FATHER — 13. Birthplace: Lithuania

MOTHER — 14. Maiden name: ?

MOTHER — 15. Birthplace: Lithunia

16. Informant: Hospital Records

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 22-46 (month) (day) (year)

Cemetery or crematory: Holy Redeemer Cem.

Location: Belair Rd

18. Funeral director: Joseph Kasmiskas Inc.

Address: 402 Washington Blvd

19. July 20, 1946 (Date rec'd by registrar) 19.....

W. Hebrank and Hole Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 18 1946, 7:25 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 14 1944, to July 18 1946 and that I last saw h..er alive on July 18, 1946 19.....

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Known since Apr. 1946
Due to	Not present 1944
Due to	
Other conditions: Mental Deficiency with Psychosis, Idiot Level	life

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Arnold H. Eichert M.D. M. D. or other

Address: Sykesville, Md. Date signed 7-18-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06901 Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 month, 20 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 733 Forrest Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: CALVIN TAYLOR

3.(b) Social Security Number: 250-34-1090

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Laura Taylor

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): August 18, 1916

8. AGE: Years	Months	Days	If less than one day
29	11	3	..... hrs. ..... min.

9. Birthplace: Sumter, S. C.
(Town, county, and state)

10. Usual occupation: Truck Driver

11. Industry or business:

FATHER — 12. Name: Calvin Taylor, Sr.
13. Birthplace: South Carolina

MOTHER — 14. Maiden name: Carrie Griffin
15. Birthplace: South Carolina

16. Informant: Deceased
Address:

17. Burial, cremation or removal. Which?: Shipped Date thereof: 7/21/46 (month) (day) (year)
Cemetery or crematory: Manning S. C.
Location:

18. Funeral director: James A Hayes
Address: Baltimore, Md.

19. 7/21 (Date rec'd by registrar) 19 46 Albert R. Swanborn Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 21, 19 46, at 9.00A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 31, 19 45, to July 21, 19 46
and that I last saw him alive on July 21, 19 46

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Aug. 15 1945
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op.:

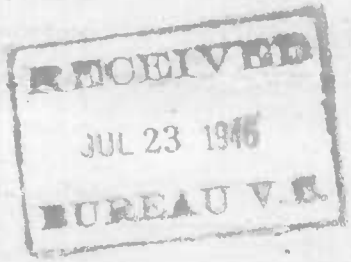
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: ..... Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other
Address: Henryton, Md. Date signed: 7/21/46

COPY SENT TO LOCAL REGISTRAR No.____ DATE 7/23/46.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (51-E)

CERTIFICATE OF DEATH

(76)

*6902 77

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Finksburg - Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 years.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Finksburg (Rural)
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: K. Monroe Taylor

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Nettie M. Hughes
6.(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): Nov 1 - 1880

8. AGE: Years	Months	Days	If less than one day
65	8	23	...hrs. ...min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business

FATHER
12. Name: Watson Taylor
13. Birthplace: Maryland

MOTHER
14. Maiden name: Eliza Evans
15. Birthplace: Maryland

16. Informant: Mrs K. M. Taylor
Address: Finksburg, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 27 1946 (month) (day) (year)
Cemetery or crematory: Wesley
Location: Carroll Co Md

16. Funeral director: Edward Tipton
Address: Hampstead Md

19 July 26 1946 John S. Hughes Jr.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 26 1946 at 7:00 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1946 to July 26 1946 and that I last saw h.im alive on July 26 1946

Immediate cause of death	DURATION
Uremia	5 days
Due to Urinary Obstruction	3 mos.
Due to Carcinoma of Prostate	9 mos
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Maurice C. Porterfield M. D. or other
Address: Hampstead Md Date signed 7-24-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06903

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 3 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5708 Swallow Lane
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: ANNIE PEARL THOMPSON

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 7, 1930

8. AGE: Years	Months	Days	If less than one day
15	11	8	hrs. min.

9. Birthplace: Atlanta, Ga. (Town, county, and state)
10. Usual occupation: Scholar
11. Industry or business: at school
FATHER 12. Name: Oren Thompson
13. Birthplace: Greens County, Ga.
MOTHER 14. Maiden name: Mattie Hall
15. Birthplace: Macon, Ga.
16. Informant: Mattie Goins
Address: 5708 Swallow Lane, Balto. Md.
17. Removal (Burial, cremation, or removal. Which?) Date thereof 7 18 46 (month) (day) (year)
Cemetery or crematory:
Location: Charlotte, N.C.
18. Funeral director: James A Hayes
Address: 142 W. Hill St. Balto. Md.
19. 7/15 (Date rec'd by registrar) 1945 Albert R. Swanson Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 15, 1946, at 11.45A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 12, 1946 to July 15, 1946 and that I last saw him alive on July 15, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Nov. 1945
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other
Address: Henryton, Md Date signed: 7/15/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06904

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 26 years, 10 months, 18 days

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 26 yrs. 10 mos. 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland ~~County~~ City: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: James M. Whaland — James Maurice Whaland

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): ~~11/14/1889~~ II/I4/I889

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
56	8	2		

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Clerk

11. Industry or business:

FATHER — 12. Name: James Patrick Whaland

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Johanna Hartigan

15. Birthplace: Maryland

16. Informant: Records of Springfield State Hospital

Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 7/19/46 (month) (day) (year)

Cemetery or crematory: St. Ignatius

Location: Hickory, Harford Co., Md.

18. Funeral director: George J. Ruth, Inc.

Address: 1735 Harford Avenue

19. 7-18 46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 16, 1946, at 7:25 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 15 1941, to July 16 1946 and that I last saw him alive on July 16 1946

Immediate cause of death	DURATION
Pulmonary tuberculosis	Known since July 10, 1946
Due to	
Due to	
Other conditions: Schizophrenia, paranoid type (Include pregnancy within 3 months of death)	1917

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: Arnold H. Eichert M.D. M. D. or other

Address: Sykesville, Maryland Date signed: 7/16/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06905

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 months, 4 days
Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 640 N. Fremont Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: BEULAH BLANCHE WILLIAMS

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	married

6.(b) Name of husband or wife: Albert Williams
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): January 27, 1894

8. AGE:	Years	Months	Days	If less than one day
	52	6	0	hrs. min.

9. Birthplace: Gibsonville, N. C.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Nancy Williamson
15. Birthplace: North Carolina

16. Informant: Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/31/46 (month) (day) (year)
Cemetery or crematory Arbutus Cem
Location Baltimore County Md
18. Funeral director Mrs. Geo H. Hatton
Address 1631 Druid Hill ave.

19. 7/27 (Date rec'd by registrar) 19 46 Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27, 19 46, at 6.30A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Nov., 23, 19 45, to July 27, 19 46
and that I last saw her alive on July 27, 19 46

Immediate cause of death: Pulmonary Tuberculosis — DURATION: Oct. 1938
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Reuben D Ruan M.D
M. D. or other
Address Henryton, Md. Date signed 7/27/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

C6906

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (16)

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 months, 9 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 537 W. Lafayette Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: ERNEST WEBSTER WRIGHT

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth data of deceased (mo., day, yr.): August 21, 1933

8. AGE: Years 12 | Months 10 | Days 20 | If less than one day: hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Scholar
11. Industry or business

FATHER
12. Name: Ernest Holland
13. Birthplace: Maryland

MOTHER
14. Maiden name: Ruth Wright
15. Birthplace: Maryland

16. Informant: Ruth Wright (Mother)
Address: 537 W. Lafayette Ave., Balto.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/14/46 (month) (day) (year)
Cemetery or crematory: Mt. Auburn
Location: Baltimore, Md.
18. Funeral director: Mr. Truxtun H. Hennelly
Address: 578 W. Biddle St.

19. July 11, 1946 (Date rec'd by registrar) Albert R. Shanklin Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 11, 1946 at 5:10A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 2, 1945 to July 11, 1946 and that I last saw him alive on July 11, 1946

Immediate cause of death	DURATION
Tuberculosis of Spine	April 1945
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Richard W. Kuman, M.D. M. D. or other
Address: Henryton, Md. Date signed: 7-11-46

(M)

MARGIN RESERVED FOR BINDING (I)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M